U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 29 June 2007

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In the Matter of:

P.E., widow of
C.E., deceased,
Claimant,

Case No. 2006-BLA-05167

v.

EMPIRE MINING, INCORPORATED/
OLD REPUBLIC INSURANCE COMPANY,
Employer/Carrier, and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party in Interest.
.....

Appearances:

Ron Carson, Program Director, Stone Mountain Health Services, St. Charles, VA
For the Claimant

Lucy G. Bowman, Esq., Street Law Firm, Grundy, VA
For the Employer

Before: PAMELA LAKES WOOD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a survivor's claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901, *et. seq.* ["the Act"] filed by Claimant P.E. ["Claimant"] on August 17, 2004 based upon the death of her husband, deceased miner C.E. ["Miner"]. The putative responsible operator is Empire Mining, Inc. ["Employer"] which is insured through Old Republic Insurance Co. ["Carrier"]. Benefits are currently being paid by the Black Lung Disability Trust Fund.

Part 718 of title 20 of the Code of Federal Regulations is applicable to this claim, as it was filed after March 31, 1980, and the regulations amended as of December 20, 2000 are applicable, as this claim was filed after January 19, 2001.[1] 20 C.F.R. §718.2. In *National Mining Assn. v. Dept. of Labor*, 292 F.3d 849 (D.C. Cir. 2002), the U.S. Court of Appeals for the D.C. Circuit rejected the challenge to, and upheld, the amended regulations with the exception of several sections.[2] The Department of Labor amended the regulations on December 15, 2003 for the purpose of complying with the Court's ruling. 68 Fed. Reg. 69929 (Dec. 15, 2003).

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, including all evidence admitted and arguments submitted by the parties. Where pertinent, I have made credibility determinations concerning the evidence.

STATEMENT OF THE CASE

On August 17, 2004, Claimant filed the current application for black lung survivor's benefits under the Act [survivor's claim], based upon the July 8, 2004 death of her husband, the Miner, at the age of 60. (DX 2).[3] The Miner had previously filed a claim in 1985 that was denied by a claims examiner at the Office of Worker's Compensation Programs in Charleston, WV in 1986 based upon all of the medical elements of entitlement. (DX 1). On February 7, 2005, a claims examiner issued a Schedule for the Submission of Additional Evidence, which indicated the preliminary conclusions that the Claimant would **not** be entitled to benefits if a decision were issued at that time and that Empire Mining Inc. and Old Republic Insurance Company were the responsible operator and insurer liable for the payment of benefits. (DX 20). On August 12, 2005, a claims examiner issued a Proposed Decision and Order, Award of Benefit—Responsible Operator. (DX 33). Following Employer's timely (September 20, 2005) request for a formal hearing (DX 40), on November 9, 2005, this matter was referred to the Office of Administrative Law Judges for a hearing (DX 43).

A formal hearing was held on March 31, 2006. Claimant was the only witness to testify. (Tr. 10-25). At the hearing, Director's Exhibits 1 through 45, Director's Exhibits 46 through 50,[4] and Employer's Exhibits 1 through 3 were admitted into evidence.[5] At the conclusion of the hearing, the record closed but the parties were allowed to submit optional briefs or written closing arguments within 30 days, subject to extension by stipulation. (Tr. 29-30). No brief was filed by Claimant.

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[1] Section and part references appearing herein are to Title 20 of the Code of Federal Regulations unless otherwise indicated.

[2] Several sections were found to be impermissibly retroactive and one which attempted to effect an unauthorized cost shifting was not upheld by the court.

[3] Director's Exhibits, Claimant's Exhibits, and Employer's Exhibits are referenced as "DX", "CX", and "EX", respectively, followed by the exhibit number. References to the hearing transcript appear as "Tr." followed by the page number.

[4] Although offered as Director's Exhibits, DX 46 to 50 are really file copies of correspondence from the Employer submitted at the district director level, together with correspondence from a claims examiner.

[5] Although DX 1, the Miner's claim, was admitted, evidence from that claim may only be considered to the extent it is in compliance with the evidentiary limitations (i.e., it has been designated by the parties or is otherwise admissible, such as a treatment note.)

Following the hearing, Employer sought additional time to submit a written closing argument but did not do so by stipulation. As there was no objection and good cause was shown, the motion is granted and the letter brief dated May 30, 2006 and filed on June 2, 2006 is accepted as timely filed. **SO ORDERED.**

ISSUES/STIPULATIONS

The issues for resolution (as listed on the CM-1025 transmittal form, as modified at the hearing) are length of employment (beyond nine years), pneumoconiosis, causal relationship with coal mine employment, causation of death, survivor, responsible operator, and insurance, as well as issues listed for appellate purposes. (DX 43, Tr. 7-8). At the hearing, Employer withdrew the issues of miner and post-1969 employment. (Tr. 6-7). It was agreed that total disability was listed in error when the case was transmitted. (Tr. 8).

With respect to length of coal mine employment, the Employer stipulated to 9 years of coal mine employment found by the Director. (Tr. 7; DX 43). Claimant correctly noted that the district director's office actually found 9.65 years (but in the summary part of the proposed decision only 9 years were listed). (Tr. 8-9, DX 22, 33).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background and Employment History

Claimant testified that she was married to the Miner in 1980 (after they lived together for about 13 years) and had not remarried since he died on July 8, 2004 at the age of 60. (Tr. 10-11). She has been disabled since 1980 due to arthritis and eye problems. (Tr. 25).

When asked how long she believed the Miner worked as a coal miner, Claimant said between twelve and fourteen years, beginning in 1964 or 1965 and continuing until 1984. (Tr. 11-15). He told her that he worked in the mines in St. Paul, Virginia, shoveling coal before he went in to the service in 1966. (Tr. 11). He also worked for several coal companies in Buchanan County and one in Wise County, starting in 1970, when he worked for J and M Coal Company in Grundy or Convict Hollow. (Tr. 12, 20). At J and M Coal Company, he worked as a roof bolter and scoop operator for approximately two years. (Tr. 12-13). After 1972, they moved back to Michigan where he worked in factories until he returned to Buchanan County in the summer of 1974 and he worked for some coal companies in Convict Hollow. (Tr. 13). For the next ten years, he worked primarily as a roof bolter and scoop operator (although he held other jobs) in the underground coal mines, and he was only out of work for approximately three months.[6] (Tr. 13-14). When he returned from the mines, he was out of breath and was covered with coal dust all over, and his clothes were so dirty that the coal dust would stop up the washing machines. (Tr. 14-15). His last coal mine job was working as a pinner man and roof bolter, putting big roof

[6] In connection with his claim as a living miner, the Miner submitted a statement saying that his last coal mine job was as a roof bolter for two to three months (from September 1984 until October or November 1984) and that he also worked for two years as a cutting machine operator, for two and one half years as a scoop operator, for two to two and one half years as a rock duster, and for two to three years as a hand loader. (DX 1)

bolts in the coal to hold it up, for Lawson Coal Company on the Guest River in Wise County. (Tr. 14, 18). He did not work anywhere else after 1984. (Tr. 16).

Claimant testified that the Miner stopped working in the mines because he was unable to breathe and his doctor, Dr. Fulton from Norton, Virginia, told him to sign up for Social Security based upon his lung disability. (Tr. 15-16). He had poor health and difficulty sleeping, and they needed to prop up the bed. (Tr. 16). Beginning in 1999 or 2000, he went on oxygen prescribed by Dr. Steven Prince, who treated him for approximately 13 years until he moved to Tennessee. (Tr. 16). He coughed up black coal dust until he got cancer and then he started coughing up blood. (Tr. 17).

On cross examination, she clarified that he first saw Dr. Fulton in 1984 or 1986, then he saw Dr. Marty Prince form 1986 to 1991, and then he saw Dr. Steven Prince. (Tr. 22). Dr. Wheatley was at Dr. Prince's office and he saw Dr. Wheatley with Dr. Prince and continuing for about three months after Dr. Prince left. (Tr. 22-23). Dr. Shukla [mistranscribed as "Shulka"] in Norton was his last physician. (Tr. 23). She accompanied the Miner to his visits with Dr. Shukla because he could not understand Dr. Shukla. (Tr. 24).

Claimant indicated that the Miner smoked Doral or Winstons back in the 70s, and the last cigarettes he smoked were Doral or GPC (Tr. 21). When asked about the smoking history recorded by Dr. Shukla, she denied that the Miner had a smoking history of two and a half to three packs a day for 50 years, explaining that they could not afford that much; rather, he smoked a pack a day and, after he was diagnosed with lung cancer, he only smoked two or three cigarettes a day.[7] (Tr. 23-24). He quit smoking entirely a couple of weeks before his death. (Tr. 24).

Varying smoking histories were recorded by the physicians who examined the Miner. According to the report by Dr. Paranthaman for the DOL examination conducted on October 23, 1985, the Miner began smoking in 1965 and smoked two to three packs per day for 20 years, cutting back to one pack per day for a couple of months. (DX 1). In a March 27, 2001 consultation note, Dr. Stephen Vest (who noted that the Miner was "not a great historian") recorded a smoking history of one pack of cigarettes per day for over 40 years. (DX 11). A history and physical exam form dated March 5, 2001 recorded a smoking history of 2 packs per day. *Id.* Dr. Wheatley recorded a 50-pack-year history, based upon one to one and one half packs of cigarettes daily, in October 2003. (EX 1). The History and Physical for his December 9, 2003 admission, signed by Dr. Joshua Crum and Dr. A.T. Shukla, recorded a smoking history of two packs of cigarettes per day for 50 years. (DX 11). The January 12, 2004 History and Physical for his next hospitalization listed a history of "one to one and one half packs per day for the past 50 years." *Id.* A January 14, 2004 consultation report by Dr. Thomas Johnson recorded a smoking history of "two and a half to three packs per day for the past 50 years but has now dropped down to about a pack a day." *Id.* The History and Physical for the April 14, 2004 admission by Dr. Shukla recorded a history of three packs per day for 40 years, recently cut back to one pack per day, while the History and Physical for the terminal hospitalization by Dr. Mitch

[7] As the Miner was born in November of 1943, he would have had to start smoking at age 10 to have smoked for 50 years prior to his death (or age 9 based upon the history recorded in December 2003). (DX 9). The Miner was diagnosed with lung cancer in December 2003. (DX 11).

Farthing listed one to one and one half packs per day for the past 50 years based upon previous records. *Id.*

Based upon the above, I find the Miner smoked from 1965, and possibly earlier, until 2004, at a rate of one pack or more until the last couple of years, and had a minimum 40-pack-year smoking history. Despite multiple references to a 50 year smoking history, I do not find it credible that the Miner began smoking at age 9 or 10. Rather, the reference may be to a 50-pack-year history. While it is clear that the Miner smoked at least one pack of cigarettes per day during most of his adult life, and that at times he probably smoked more, the discrepancies in the medical records are significant enough so that I must rely upon Claimant's testimony of about one pack per day.

The Social Security records reflect six quarters of coal mine employment in 1963 and 1964 [1½ yrs.], two quarters in 1975 [½ yr.], and continuous coal mine employment from 1976 to 1983 [8 yrs.] and part of 1984 (DX 1, 6). Allowing for one quarter in 1984, that would amount to ten years and one quarter years of coal mine employment, and I so find.

The Social Security records also reflect that the last coal mine employer that employed the Miner for more than one cumulative year was Empire Mining, Inc. in Grundy, VA (Employer), for which he worked in 1982, 1983, and part of 1984; he also worked for two other coal mine employers (T & C Coal Co. in Vansant, VA and Lawson Mining Company Inc. in Wise VA) in 1984. (DX 6). Thus, Employer was properly named as responsible operator.

Medical Evidence

Death Certificate

According to the death certificate, signed by Dr. A. T. Shukla, the Miner was born in November 1943 and died on July 8, 2004 at Norton Community Hospital, at the age of 60. The immediate cause of death was listed as "Metastatic Cancer of Lung." (DX 9). No underlying causes or other significant conditions were listed. *Id.* The death certificate was signed by Dr. Shukla on July 12, 2004 and was prepared without benefit of the autopsy results. *Id.*

Medical Records

Records from Norton Community Hospital primarily reflect the Miner's treatment for lung cancer from December 2003 to his terminal hospitalization in July 2004. (DX 11 [mislabeled as DX 12]).[8] Diagnoses for these hospitalizations included metastatic lung cancer, pneumonia, and chronic obstructive pulmonary disease. *Id.* Also included are records from 2001, including a March 2001 cystoscopy and April 2001 colonoscopy; in the March 5, 2001 history and physical exam, "Black lung, emphysema, and COPD" are listed by history. *Id.* There is also a one page emergency room record (undated, but either late 1999 or 2000 based

[8] There is another DX 12 identified as "Hospital Treatment Records" that is five pages long and includes statements of treating physicians. In the index to the Director's Exhibits, 121 pages of "Hospital Treatment Records" are identified at DX 11. (DX 44).

upon the Miner's recorded age of 56) reflecting complaints of shortness of breath and chest pain and a diagnosis of COPD. *Id.*

Chest x-rays were taken during the hospitalizations. A December 10, 2003 x-ray was interpreted by Dr. Srikumar Gopalan as showing chronic obstructive pulmonary disease and a large cavitary mass (reflecting an infectious process or a cavitary neoplasm.) (DX 11). A CT scan of the thorax dated December 27, 2003 without contrast reflected a large (8.4 x 6 cm.) cavitary mass in the right lower lobe and enlarged lymph nodes suspicious of metastatic disease. *Id.* Readings of subsequent x-rays and CT scans recorded similar findings and identified the mass as consistent with the Miner's known lung cancer. *Id.* None of the x-rays or CT scans mentioned pneumoconiosis or silicosis. *Id.*

Also of record are the following physicians' records:

1. Dr. Shukla's office records for December 2003 to April 2004. (DX 10). These records reflect diagnoses of COPD and squamous cell carcinoma of the lung. *Id.*
2. Office notes from Drs. Prince and Wheatley from December 10, 1987 through December 4, 2003. (EX 1). These records reflect that the Miner was first treated by Dr. Prince for chronic obstructive pulmonary disease in December 1987 and that he had been experiencing dyspnea since 1983 that had progressively worsened and was accompanied by wheezing. During the initial (December 10, 1987) treatment note, Dr. Prince recorded an 11 year history of underground coal mining and a longstanding history of cigarette smoking. The Miner was subsequently treated for asthmatic bronchitis/severe COPD for which he was prescribed bronchodilators and a nebulizer.
3. Radiology reports included in Drs. Prince and Wheatley's records. (EX 1). These include a radiology report from Norton Community Hospital by G. Thomas Haines, M.D. dated February 12, 1997 reflecting a diagnosis of "Chronic obstructive pulmonary disease; no acute cardiopulmonary process." A November 17, 2003 CT scan of the chest read by Dr. Mannachanallur Ramarkrishnan showed a 6 cm. cavitating mass, emphysematous lungs, and enlarged lymph notes; a chest x-ray of the same date was interpreted by Dr. Ramarkrishnan as showing a 7 cm. mass and emphysematous lungs.

Medical Opinions

In addition to the death certificate and medical/hospital records discussed above, the record includes the following medical opinions:

(1) The medical examination report of Dr. S. K. Paranthaman for the DOL examination of October 23, 1985 including chest x-ray interpretations, pulmonary function studies, arterial blood gases, and electrocardiograms. (DX 1, EX 3). Dr. Paranthaman found "very minimal" functional impairment related to the respiratory system. He diagnosed chronic bronchitis and hypertension by history. In the portion of the form asking whether the diagnosed condition was related to dust exposure in coal mine employment, he stated:

> Chest x-ray shows early changes of coal workers' pneumoconiosis 0/1, p/s, Bu. Chronic bronchitis is probably due to cigarette smoking (heavy) and to a lesser extent coal dust exposure.

Id. The chest x-ray of October 23, 1985 was interpreted by board-certified radiologist Dr. Shiv Navani as showing p/s opacities, 0/1 profusion, in the 5 lower zones, together with "bu" (bullae). The same x-ray was interpreted as negative for pneumoconiosis, but showing "em" [emhysema] by B-reader Dr. Dominic Gaziano. (DX 1).

(2) An Autopsy was conducted by pathologist Julie S. Robertson, M.D. at Norton Community Hospital on July 9, 2004 and reported on August 18, 2004. The final anatomic diagnosis was:

> I. Respiratory system:
> A. Poorly differentiated squamous cell carcinoma, right upper lobe (5 cm) and left upper lobe (5 cm).
> B. Emphysematous changes.
> C. Moderate to severe anthracosis.
>
> II. Cardiovascular System:
> A. Heart, 562 grams.
> B. Coronary atherosclerotic disease.
> 1. Left descending coronary artery, 95% stenosis.
> 2. Right coronary artery, 95% stenosis.

(DX 11). The two-page report, signed by pathologist Julie S. Robertson, M.D., included a diagnosis section, a clinical summary, and a gross description. It did not, however, include a microscopic description. The autopsy report is discussed further below.

(3) A March 23, 2005 letter report from Michael W. Wheatley, M.D., the Miner's treating physician stated the following:

> I feel that [Miner's] [coal]worker's pneumoconiosis contributed to and/or hastened his death. I feel that the worsening of his COPD caused a worsening of his respiratory failure and predisposed him to a more rapid decline. I began treating [Miner] about six months prior to his death. I think the black lung did contribute to his death, but the cause of death was felt to be lung cancer.
>
> He probably would have tolerated the lung cancer for a greater period of time had he not had such marked compromise of his respiratory function.

(DX 12).

(4) A June 23, 2005 letter report from Steven R. Prince, M.D., the Miner's treating physician indicated that he had treated the Miner from 1990 to 2003 and that he had a history of 13 years of extreme coal dust exposure, working on a cutting machine; a smoking history of 30+ years; and shortness of breath for approximately 20 years, accompanied by cough, sputum production and wheezing. (DX 12) He treated the Miner with aggressive inhaled bronchodilator therapy in the form of Advair and albuterol. *Id.* There had been a negative workup for cardiac

problems and there was no evidence of congestive heart failure. *Id.* Dr. Prince noted that the Miner had developed lung carcinoma diagnosed in December 2003 and he subsequently died in July 2004; he noted that the autopsy showed "moderate to severe coal workers pneumoconiosis by path report." *Id.* Dr. Prince opined:

> To summarize, the patient did have definite and severe respiratory problems and this was based on clinical presentation of symptoms and, based on his autopsy report, I feel it is clear that at least a large part of his symptoms was related to coal dust exposure and coal workers pneumoconiosis. There is no question that he had a severe breathing impairment that, prior to his death, markedly decreased his ability to function with normal activities of daily living.

(DX 12).

(5) Dr. Erika Crouch, a pathologist and Professor of Pathology & Immunology at the Washington University in St. Louis School of Medicine, prepared a Pulmonary Pathology Consultation Report dated February 20, 2006.[9] (EX 2). Her opinion was based upon her microscopic review of the eight glass slides or cassettes taken during the autopsy.[10] The Microscopic section of the report noted:

> The sections of lung tissue are remarkable for extensive areas of invasive, poorly differentiated carcinoma with squamous differentiation consistent with a lung primary. Sections show extensive tumor necrosis with areas of abscess formation and areas of reparative fibrous proliferation. There is evidence of chest wall extension. The small amount of uninvolved parenchyma shows small amounts of black to dark brown particles consistent with coal dust and more abundant rounded black pigments consistent with carbonaceous combustion products derived from cigarette smoke. Polarization microscopy reveals small amounts of short needle-like particles consistent with silicates. One section shows an area of hyaline fibrosis involving a pulmonary lymph node. However, there are no coal dust macules, parenchymal dust nodules or larger coal dust lesions.

(EX 2). Under the "Diagnosis" section of the report, Dr. Crouch listed:

> Lungs, autopsy -: extensive poorly differentiated carcinoma consistent with lung primary
> -: coal dust deposition but no evidence of pneumoconiosis

Id. In the "Comment" section, Dr. Crouch explained that the lungs showed "evidence of coal dust deposition with morphological features suggesting the inhalation of coal dust containing

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[9] Although Employer listed Dr. Crouch's "professional qualifications" on Employer's Exhibit List as being included in EX 2, on the first page of the bound copy of Employer's exhibits, it was not included in the exhibit package or elsewhere in the record. As identified and admitted at the hearing, only "the report by Dr. Erica Crouch dated February 20, 2006" was included in EX 2. (Tr. 26-27).

[10] According to the autopsy report, there were eight cassettes identified as 1-3 rs, tumor, RUL; 4-5 rs, RUL; 6-7 rs, RML; 8 rs, RLL; 9-11 rs, tumor, LUL; 12-13 rs, RML; 14-15 rs, RML; and 16-17 rs, posterior rib adjacent to RUL tumor. Dr. Crouch also received a copy of the autopsy report that described the cassettes. Thus, Dr. Crouch appears to have reviewed all of the specimens taken during the autopsy.

crystalline silica" consistent with occupational exposure but no evidence of pneumoconiosis in the form of coal dust macules, micronodules, larger coal dust lesions, or parenchymal silicotic nodules. *Id.* She opined that the "observed parenchymal fibrosis can be attributed to tumor with associated necrosis and pneumonia" and she noted that the lung showed "extensive abnormalities attributed to wide spread invasive carcinoma." *Id.* She concluded:

> Thus, coal dust inhalation could not have caused any clinically significant degree of respiratory impairment or disability and could not have caused, contributed to, or otherwise hastened this patient's death secondary to complications of wide spread carcinoma, consistent with a lung primary.

(EX 2). Dr. Crouch's report is discussed further below.

DISCUSSION AND ANALYSIS

Evidentiary Limitations

My consideration of the medical evidence is limited under the regulations, which apply evidentiary limitations to all claims filed after January 19, 2001. 20 C.F.R. §725.414. Section 725.414, in conjunction with Section 725.456(b)(1), sets limits on the amount of specific types of medical evidence that the parties can submit into the record. *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-47 (2004) (en banc), BRB No. 03-0615 BLA (June 28, 2004) (en banc) (slip op. at 3), citing 20 C.F.R. §§725.414; 725.456(b)(1). Under section 725.414, the claimant and the responsible operator may each "submit, in support of its affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports." *Id.*, citing 20 C.F.R. §725.414(a)(2)(i),(a)(3)(i). In rebuttal of the case presented by the opposing party, each party may submit "no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by" the opposing party "and by the Director pursuant to §725.406." *Id.*, citing 20 C.F.R. §725.414(a)(2)(ii), (a)(3)(ii). Following rebuttal, each party may submit "an additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing," and, where a medical report is undermined by rebuttal evidence, "an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence." *Id.* "Notwithstanding the limitations" of section 725.414(a)(2),(a)(3), "any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence." *Id.*, citing 20 C.F.R. §725.414(a)(4). Medical evidence that exceeds the limitations of Section 725.414 "shall not be admitted into the hearing record in the absence of good cause." *Id.*, citing 20 C.F.R. §725.456(b)(1).

The parties cannot waive the evidentiary limitations, which are mandatory and therefore not subject to waiver. *Phillips v. Westmoreland Coal Co.*, 2002-BLA-05289, BRB No. 04-0379 BLA (BRB Jan. 27, 2005) (unpub.) (slip op. at 6).

The Benefits Review Board discussed the operation of these limitations in its en banc decision in *Dempsey, supra.* First, the Board found that it was error to exclude CT scan evidence because it was not covered by the evidentiary limitations and instead could be considered "other medical evidence." *Dempsey* at 5; see 20 C.F.R. § 718.107(a) (allowing consideration of medical evidence not specifically addressed by the regulations). Second, the Board found that it was error to exclude pulmonary function tests and arterial blood gases derived from a claimant's medical records simply because they had been proffered for the purpose of exceeding the evidentiary limitations. *Dempsey* at 5. Third, the Board held that state claim medical evidence is properly excluded if it contains testing that exceeds the evidentiary limitations at § 725.414. In so holding, the Board noted that such records did not fall within the exceptions for hospitalization or treatment records or for evidence from prior federal black lung claims. *Dempsey* at 5. Fourth, on the issue of good cause for waiver of the regulations, the Board noted that a finding of relevancy would not constitute good cause and therefore records in excess of the limitations offered on that basis, and on the basis that the excluded evidence would be "helpful and necessary" for the reviewing physicians to make an accurate diagnosis, were properly excluded. *Dempsey* at 6. Finally, the Board stated that inasmuch as the regulations do not specify what is to be done with a medical report that references inadmissible evidence, it was not an abuse of discretion to decline to consider an opinion that was "inextricably intertwined" with excluded evidence. *Dempsey* at 9. Referencing *Peabody Coal Co. v. Durbin*, 165 F.3d 1126, 21 BLR 2-538 (7th Cir. 1999), the Board acknowledged that it was adopting a rule contrary to the common law rule allowing inadmissible evidence to be considered by a medical expert, because "[t]he revised regulations limit the scope of expert testimony to admissible evidence." *Dempsey* at 9-11.

As the Board noted in *Dempsey*, the regulations specifically allow evidence from a prior claim to be considered in connection with a later claim, so that a determination may be made whether there has been a material change in conditions since the time of the prior claim, 20 C.F.R. §725.309(d)(1); however, there is no such provision applicable to survivor's claims that would allow consideration of the evidence developed in the miner's claims, absent a finding of good cause. Consistent with the above limitations and the Board's decision in *Dempsey*, other administrative law judges have generally excluded evidence developed in connection with a miner's claim from consideration in a surviving spouse's claim to the extent that the limitations have been exceeded, unless the case involves a consolidated miner's claim and survivor's claim. However, in *Keener v. Peerless Eagle Co.*, BRB No. 05-1008 BLA (BRB Jan. 30, 2007) (en banc), the Board held that even if the cases are consolidated, there should be separate records for a miner's claim and a survivor's claim. In *Keener*, the Board also found that an autopsy rebuttal should be confined to a slide review.

The evidence in the instant case is in compliance with the evidentiary limitations. There was a single medical examination report (including test results) present in DX 1, the claim the Miner filed during his lifetime, and that report by Dr. Paranthaman was designated by Employer as EX 3. Claimant submitted two medical opinion reports and the original autopsy report and Employer submitted one autopsy slide review (which is also a medical opinion). The remaining records were medical records. The only evidentiary issue in the instant case relates to the x-ray interpretations from Dr. Paranathaman's examination, which were not designated by either party. Only the one by Dr. Navani appears in EX 3. Inasmuch as none of the x-ray readings are

positive for pneumoconiosis under the regulations, the consideration of these readings (the only ones in compliance with the ILO system) will not affect the outcome of this case.

Medical Issues

To establish entitlement to benefits as an eligible survivor of a miner whose death was due to pneumoconiosis, a claimant must establish that the miner had pneumoconiosis, that the pneumoconiosis arose out of coal mine employment, and that the miner's death was due to pneumoconiosis. 20 C.F.R. § 718.205(a).

The Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 281 (1994). In *Greenwich Collieries*, the Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants. Thus, in order to prevail in a black lung case, the claimant must establish each element by a preponderance of the evidence.

Existence of Pneumoconiosis

The regulations provide several means of establishing the existence of pneumoconiosis: (1) a chest x-ray meeting criteria set forth in 20 C.F.R. §718.102, and in the event of conflicting x-ray reports, consideration is to be given to the radiological qualifications of the persons interpreting x-ray reports; (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. §718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" set forth in 20 C.F.R. §718.304 (or two other presumptions set forth in §718.305 and §718.306); or (4) a determination of the existence of pneumoconiosis as defined in §718.201 made by a physician exercising sound judgment, based upon objective medical evidence and supported by a reasoned medical opinion. 20 C.F.R. §718.202(a) (1)-(4). Under section 718.107, other medical evidence, and specifically the results of medically acceptable tests and procedures which tend to demonstrate the presence or absence of pneumoconiosis, may be submitted and considered. As this case arises in the Fourth Circuit, all of the evidence from section 718.202 should be weighed together in determining whether a miner suffers from pneumoconiosis. *See, e.g., Island Creek Coal Co. v. Compton*, 211 F.3d 203, 208-209 (4th Cir. 2000). *But see Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (en banc) (noting "the Sixth Circuit has often approved the independent application of the subsections of Section 718.202(a) to determine whether claimant has established the existence of pneumoconiosis.")

Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986).

In the December 2000 amendments to the regulations, the definition of pneumoconiosis in section 718.201 was amended to provide for "clinical" and "legal" pneumoconiosis and to acknowledge the latency and progressiveness of the disease.

- Clinical pneumoconiosis consists of "those diseases recognized by the medical community as pneumoconioses, *i.e.,* the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment." The definition "includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis. . ." *Id.*
- Legal pneumoconiosis is defined as "any chronic lung disease or impairment and its sequelae arising out of coal mine employment." 20 C.F.R. §718.201(a). The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. §718.201(b). Notably, in amending the regulations, the Department of Labor discussed the strong epidemiological evidence supporting an association between coal dust exposure and obstructive pulmonary disability (65 Fed. Reg. 79937-79945 (Dec. 20, 2000)), but it nevertheless chose to require that each individual claimant establish by a preponderance of the evidence that such an association occurred in that individual's case. *Id.* at 79938.

X-ray evidence. There is no x-ray evidence of pneumoconiosis. The only x-ray readings taken in accordance with the ILO system were taken during the Miner's DOL examination in 1985. Although the Miner's chest x-ray of October 23, 1985 was interpreted by board-certified radiologist Dr. Shiv Navani as showing p/s opacities, 0/1 profusion, in the 5 lower zones, together with "bu" (bullae), that is not evidence of pneumoconiosis, although it is not evidence of the absence of pneumoconiosis either. Under 20 C.F.R. § 718.102 a chest x-ray classified as 0-, 0/0 or 0/1 under any of the classification systems "does not constitute evidence of pneumoconiosis." The same x-ray was read by a B-reader (Dr. Gaziano) as negative for pneumoconiosis but showing emphysema. While some of the other x-rays showed COPD, there is no basis for associating that finding (or the finding of emphysema) with pneumoconiosis. Thus, the x-ray evidence does not establish whether Miner was suffering from pneumoconiosis.

Autopsy and Biopsy Evidence. A claimant may prove the existence of pneumoconiosis through autopsy or biopsy evidence. 20 C.F.R. §718.202(a)(2). The regulation makes clear that the mere presence of anthracotic pigmentation in itself is not enough to establish pneumoconiosis. *Id*.; *see also Hapney v. Peabody Coal Co.*, 22 B.L.R. 1-106 (2001) (en banc). The autopsy evidence, which is summarized in more detail *supra,* includes (1) the autopsy report by pathologist Dr. Julie Robertson, which found squamous cell carcinoma, emphysematous changes, and moderate to severe anthracosis; and (2) the autopsy slide review by pathologist Dr. Erica Crouch, which found extensive carcinoma and coal dust deposition but no evidence of pneumoconiosis.

Turning first to Dr. Robertson's autopsy report, I am unable to agree that her diagnosis of "anthracosis" is tantamount to a diagnosis of clinical pneumoconiosis. Although the definition of "clinical pneumoconiosis" in section 718.201(a)(1) specifically includes "anthracosis," section 718.202(a)(2) provides that a finding in an autopsy of anthracotic pigmentation "shall not be

sufficient, by itself, to establish the existence of pneumoconiosis." By definition, "anthracosis" is "accumulation of carbon from inhaled smoke or coal dust in the lungs." *Stedman's Concise Medical Dictionary* at 64 (2d ed. 1994). Thus, a diagnosis of anthracosis does not necessarily reflect the "permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition" that is characteristic of clinical pneumoconiosis, as defined in section 718.201(a)(1).

Even if the diagnosis of "anthracosis" were deemed to be the equivalent of a diagnosis of clinical pneumoconiosis, it is unsupported by specific microscopic findings. In this regard, the autopsy report by Dr. Robertson provides a gross description of findings related to the respiratory system, which findings include moderate to severe anthracosis and external surfaces which are uniformly black and remarkable for two irregular necrotic tan tumors in the left upper lobe and right upper lobe. The description goes on to note:

> The cut surfaces of the lungs show moderate emphysematous changes and confluent black patches grossly consistent [with] severe anthracosis.

(DX 11). The report goes on to note minimal vascular congestion, mild pulmonary edema, enlarged lymph nodes (showing tumor involvement), unremarkable intrapulmonary bronchial tree and pulmonary vasculature, and no emboli. However, while there is a list of eight cassettes relating to the various parts of the lung, there is absolutely no discussion of what the slides show. The report is therefore deficient because it lacks microscopic findings. *See* 20 C.F.R. §718.106(a) (requiring autopsy report to include "a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung.") Thus, the autopsy report is insufficient to establish clinical pneumoconiosis.

Turning to Dr. Crouch's slide review, I find that it does satisfy the regulatory requirements. Specifically, Dr. Crouch reviewed the specimens taken during the autopsy and found them to reflect coal dust deposition but not pneumoconiosis. (EX 2) Under the Microscopic section of the report, she noted the presence of "extensive areas of invasive, poorly differentiated carcinoma with squamous differentiation with a lung primary" and "extensive tumor necrosis with areas of abscess formation and areas of reparative fibrous proliferation." *Id.* She went on to note the presence of "black to dark brown particles consistent with coal dust and more abundant rounded black pigments consistent with carbonaceous combustion products derived from cigarette smoke" and (on polarization microscopy) "small amounts of short needle-like particles consistent with silicates" but "no coal dust macules, parenchymal dust nodules or larger coal dust lesions." *Id.* As related to the lungs, Dr. Crouch diagnosed "extensive, poorly differentiated carcinoma consistent with lung primary" and "coal dust deposition but no evidence of pneumoconiosis." In the "Comment" section, she explained:

> The lungs show evidence of coal dust deposition with morphological features suggesting the inhalation of coal dust containing crystalline silica. The findings are consistent with occupational exposure. However, there is no evidence of pneumoconiosis. In particular, no coal dust macules, micronodules or larger coal dust lesions are identified. No parenchymal silicotic nodules are identified. The

> observed parenchymal fibrosis can be attributed to tumor with associate necrosis and pneumonia. . . .

(EX 2). Thus, Dr. Crouch, the only pathologist to provide a microscopic description of the lung tissue, did not find it to show evidence of pneumoconiosis.

In view of the above, I find that Claimant cannot establish pneumoconiosis based upon the autopsy evidence.

Complicated Pneumoconiosis and Other Presumptions. There is no evidence of complicated pneumoconiosis, in that the large mass identified on x-rays was found to be a tumor; therefore, the associated irrebuttable presumption regarding complicated pneumoconiosis does not apply. The additional presumptions described in section 718.202(a)(3), which are set forth in 20 C.F.R. §718.305 and 20 C.F.R. §718.306, are also inapplicable because they do not apply to claims filed after January 1, 1982, or June 30, 1982, respectively. Therefore, Claimant has not established pneumoconiosis through section 718.202(a)(3).

Medical Opinions on Pneumoconiosis. As discussed above, in addition to the autopsy evidence, there were three medical opinions of record: (1) the opinion by Dr. Paranthaman based upon the DOL examination of October 23, 1985 (DX 1, EX 3); (2) the posthumous (March 23, 2005) medical opinion of treating physician Dr. Wheatley (DX 12); and (3) the posthumous (June 23, 2005) medical opinion of treating physician Dr. Prince (DX 12).

None of these opinions establishes clinical pneumoconiosis. Dr. Paranthaman found early changes of coal workers' pneumoconiosis based on an 0/1 x-ray reading but, as noted above, such a reading cannot constitute evidence of pneumoconiosis under the regulations. *See* 20 C.F.R. § 718.102. Drs. Wheatley and Prince accepted a diagnosis of coal workers' pneumoconiosis. Dr. Prince based his diagnosis upon the autopsy report but, as noted above, that report was deficient because it did not list microscopic findings and the only pathologist making microscopic findings did not find pneumoconiosis. *See* 20 C.F.R. §718.202(a)(2). It is unclear what the basis for Dr. Wheatley's diagnosis was, but it lacks probative value in view of the absence of a discussion of its basis. Notably, neither treating physician diagnosed coal workers' pneumoconiosis or silicosis when treating the Miner.

These medical opinions do not establish legal pneumoconiosis, either. While the Miner's treating physicians, Drs. Wheatley and Prince, found him to suffer from COPD and asthmatic bronchitis, they did not state that coal mine dust was an etiological factor contributing to those conditions. Dr. Paranthaman did, however, diagnose chronic bronchitis in 1985 and he stated that it was probably due to heavy cigarette smoking and to a lesser extent coal dust exposure. However, Dr. Paranthaman did not provide any analysis supporting his inclusion of coal dust as an etiological factor. Further, his opinion is remote in time, and an opinion that bronchitis suffered by a miner less than one year after he left the mines was caused by coal dust is not the same as an opinion that bronchitis or COPD suffered by the same miner almost 20 years later was caused by coal dust. Thus, I find the medical opinion evidence does not establish legal pneumoconiosis either.

In view of the above, I find the Claimant has failed to establish that the Miner was suffering from clinical or legal pneumoconiosis at the time of his death based upon the medical opinion evidence.

Other Evidence of Pneumoconiosis. The hospital and treatment records, discussed above, do not establish either clinical or legal pneumoconiosis. Specifically, the x-ray and CT scans reported in these records do not reflect a finding of either coal workers' pneumoconiosis or silicosis. Although they show COPD, it has not been etiologically related to coal dust exposure, and the mass in the lungs appearing on x-rays was determined to represent lung cancer. The medical and hospital records, while listing COPD as a diagnosis, do not implicate coal mine dust as a causative agent. There was a single entry (by Dr. Concepcion, in 2001) listing "Black Lung" by history, but such an entry has no probative value absent further explanation. The medical records do not, therefore, assist Claimant in establishing pneumoconiosis.

All Evidence on Pneumoconiosis. Taking into consideration all of the above evidence, I find that Claimant has not demonstrated that the Miner suffered from clinical pneumoconiosis or legal pneumoconiosis. Each category of evidence falls short of establishing pneumoconiosis, and the evidence considered as a whole, in view of the autopsy evidence, also falls short.

Casual Relationship with Coal Mine Employment

As Claimant has not proven that the Miner was suffering from simple coal workers' pneumoconiosis, she cannot prove that it arose from coal mine employment. In this regard, under 20 C.F.R. §718.203(b), if a claimant establishes that a miner had pneumoconiosis and also establishes at least 10 years of coal mine employment in one or more coal mines, there is a rebuttable presumption that the pneumoconiosis arose from coal mine employment. Although I have found that the Miner had at least ten years (ten years and one quarter) of coal mine employment, I have also found that Claimant has not established that the Miner suffered from pneumoconiosis. I therefore find that Claimant has not established that the Miner's pneumoconiosis arose from his coal mine employment either directly or presumptively.

Causation of Death

Since the claim was filed after January 1, 1982, the issue of death due to pneumoconiosis is governed by §718.205(c), as amended, which states, in pertinent part:

> For the purpose of adjudicating survivor's claims filed on or after January 1, 1982, death will be considered to be due to pneumoconiosis if any of the following criteria is met:
>
> (1) Where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death, or
>
> (2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or

(3) Where the presumption set forth at §718.304 is applicable.[11]

(4) However, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death.

(5) Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death.

20 C.F.R. §718.205(c).

At the outset, I note that because the Claimant has not established that the Miner suffered from pneumoconiosis, she cannot establish that it caused, contributed to, or hastened his death.

There were two medical opinions addressing the issue of whether the Miner's death was caused or hastened by pneumoconiosis:

First, Dr. Wheatley, the Miner's treating physician for a short period of time, found that the Miner's coal workers' pneumoconiosis/black lung contributed to his death from lung cancer, because he would have tolerated the cancer for a greater period of time if he had not had such a marked compromise of his respiratory system. However, the diagnosis of coal workers' pneumoconiosis and black lung was unsupported, as discussed above. Dr. Wheatley also opined that "the worsening of his COPD caused a worsening of his respiratory failure and predisposed him to a more rapid decline" but Dr. Wheatley did not associate the Miner's COPD with coal mine dust. Thus, Dr. Wheatley's opinion falls short of establishing that pneumoconiosis caused or hastened the Miner's death.

Second, Dr. Crouch opined that coal dust inhalation could not have caused, contributed to, or hastened the Miner's death. She explained her findings, noting the extensive abnormalities (including fibrosis) attributed to wide spread invasive carcinoma and (despite coal dust deposition) the lack of evidence of pneumoconiosis, and she concluded that coal dust inhalation could not have caused any clinically significant degree of respiratory impairment or disability. She therefore concluded that it did not cause, contribute to, or otherwise hasten his death "secondary to complications of wide spread carcinoma, consistent with a lung primary." Dr. Crouch's opinion rests upon her interpretation of the autopsy slides; however, as there were no microscopic findings in the autopsy report, her interpretation of the slides is essentially unrefuted.

Dr. Prince, the Miner's treating physician for many years, stated his opinion that a large part of the Miner's respiratory symptomatology was due to coal workers' pneumoconiosis, but he did not address its possible contribution to the Miner's death. Moreover, his opinion was based upon the autopsy report which, as noted above, falls short of establishing pneumoconiosis. His own office records do not support a finding of coal workers' pneumoconiosis. His opinion is therefore of little use on the issue of whether it contributed to the Miner's death.

[11] The presumption in section 718.304 relates to complicated pneumoconiosis.

As noted above, Dr. Paranthaman's opinion is too remote in time to have any probative value on the cause of the Miner's death.

The autopsy report by Dr. Robertson, discussed above, provided a diagnosis of anthracosis but did not address any possible contribution by the anthracosis to the Miner's death. As noted above, I have already found that the diagnosis of anthracosis was insufficient to establish clinical pneumoconiosis.

None of the other evidence assists the Claimant in establishing that the Miner's death was caused, contributed to, or hastened by pneumoconiosis.

- The death certificate by Dr. Shukla attributed the Miner's death entirely to metastatic cancer of the lung and did not list any contributory causes or other significant conditions. (DX 9).
- Records from the Miner's terminal (July 8, 2004) hospitalization reflect that he presented to the emergency room due to somnolence and lethargy. Past medical history on admission included lung cancer with metastasis to the brain, chronic obstructive pulmonary disease, esophageal reflux, benign prostatic hyperplasia, and seizure disorder secondary to cerebral metastasis from lung cancer. Examination of the lungs showed audible rhonchi and apneic episodes were suspected. The Miner eventually became unresponsive and a decision was made not to resuscitate. The final diagnoses were metastatic lung cancer, acute delirium secondary to urinary tract infection, poor po [by mouth] intake, and lethargy and insomnia [probably should be somnolence]. (DX 11). These records do not make any mention of pneumoconiosis or the Miner's coal mine dust exposure and do not discuss the etiology of the Miner's COPD and what, if any, part it may have played in causing or hastening his death.
- None of the medical or hospital records associate the Miner's lung cancer with his coal mine dust employment. (DX 10, 11; EX 1).

In view of the foregoing, I find that Claimant has not established death due to pneumoconiosis under §718.205(c), or by any other means.

Conclusion

The record does not establish that the Miner suffered from either clinical or legal pneumoconiosis or that pneumoconiosis caused, contributed to, or hastened the Miner's death. Therefore, I find that the Claimant is not entitled to benefits under the Act and applicable regulations and it is not necessary to consider any other issues.

ORDER

IT IS HEREBY ORDERED that the claim of P.E., surviving spouse of C.E., a deceased coal miner, for benefits under the Black Lung Benefits Act be, and hereby is **DENIED.**

A

PAMELA LAKES WOOD
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207.

Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen H. Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).